R.N.

A JOURNAL FOR NURSES

MARCH 1940

It's a message he expected, since he had prescribed an evaporated milk bottle formula

Listen to a well-known pediatrician: "I prescribe evaporated milk for infant feeding when breast milk fails because I know how dependable it is." That sentiment is echoed by an army of doctors, the country over!

If you'd like a brand that has that dependability—*as well as* economy—consider White House Evaporated Milk.

Its butterfat content averages 7.84%, its total solids content 26.3%. Made from the pure sweet milk of more than 80,000 cows from tuberculin-tested herds, it is safe, nourishing and wholesome. Its curd tension is zero and free of pathogenic organisms. Unbiased laboratory tests report it to be sterile. It's homogenized, making it quickly digested: the fat globules of ordinary milk are broken into tiny particles and blended evenly throughout White House. It is accepted by the American Medical Association's Council on Foods, approved by Good Housekeeping Bureau. It conforms to all Government standards. It is made, guaranteed and sold at an economy price by A&P.

Please remember that White House assures all customers: "Double your money back if you're not 100% satisfied."

SAMPLE FORMULAS

(Formula contains 220 calories)
White House Evap. Milk—4 ounces
Sterile water—14 ounces
Sugar—½ ounce
Six bottle feedings—3 ounces each

(Formula contains 440 calories)
White House Evap. Milk—8 ounces
Sterile water—16 ounces
Sugar—1 ounce
Six feedings—4 ounces at 4-hour intervals.

Normal babies usually require between 45 and 50 calories per lb. to gain weight.

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IN *This* ISSUE

March 1940 Vol. 3, No. 6

Cover photo by Ray Albert

A JOURNAL RN FOR NURSES

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Debits and credits

INSURANCE THE ANSWER?

Dear Editor:

Would nurses be less inclined to seek aid from the C.I.O. or the A.F. of L. if their own associations offered some form of insurance? As it is, nurses in small cities feel that little benefit is derived from money spent in dues.

Is it not possible for our State organizations to secure reliable, and not too costly insurance, to be paid for with dues? The money, paid at stated intervals, could go toward a retirement fund or could be withdrawn if needed by the nurse for an emergency.

Let us offer our own security for nurses so that they will not be influenced by trade unions. Somehow, it seems that our ideals and dignity should not be sacrificed. Let us not forget the pledge we made on graduation: "I will do all in my power to elevate the standard of my profession."

Is it elevating our standards to join the C.I.O. or A.F. of L.?

Celestine M. Steger, R.N.
Tiffin, Ohio

[*The A.N.A. recommends the Harmon Plan insurance for nurses. Premiums are paid, however, from the nurse's private funds, not from her association dues.* R.N. *has not investigated the Harmon Plan, is therefore unable to comment on its merits.*—THE EDITORS]

CAUSES

Dear Editor:

I'd like to reply to the letter in your December issue entitled "Soured?"

Before passing judgment on all graduate-staffed hospitals and on the graduates themselves, I wonder if it ever occurred to your correspondent to find out if the nurses were really sour, and if so *why*. An investigation of the nurses' living quarters and dining room might reveal the reason.

Before drawing comparisons between the student and graduate nurse, one should investigate the off-duty responsibilities of each. For the average student, life consists largely of training, obedience to rules, hygienic living, and having a good time whenever hours-off and studies permit.

Since the depression years, the majority of older nurses whom I have known are doing general duty to keep home and family, as well as body and soul together. After putting in ten hours a day at floor duty, many go home to husband and children, or to parents and younger brothers and sisters. Many are not well, but keep on because there is nothing else to do.

The writer of "Soured" may be a carefree young woman. But it seems to me that if she is going to be *really* fair, she should look beneath the surface before drawing conclusions.

Sybil E. Watson, R.N.
New York, N.Y.

SOCIAL SECURITY

Dear Editor:

What is going to happen to the hundreds of nurses and hospital employees who are not included in the Social Security Act?

Don't you think our nursing associations should get busy on this? Please publish an article on Social Security for nurses.

Deborah Haynes, R.N.
Staten Island, N.Y.

[*Scores of letters from readers have convinced* R.N. *that nurses want information on Social Security. A series of articles has been scheduled for* 1940.—THE EDITORS]

SAFETY INFORMATION

Dear Editor:

The article "Salesman for Safety," published in December, interested me because I serve just such a large personnel in the Federal Land Bank of Spokane.

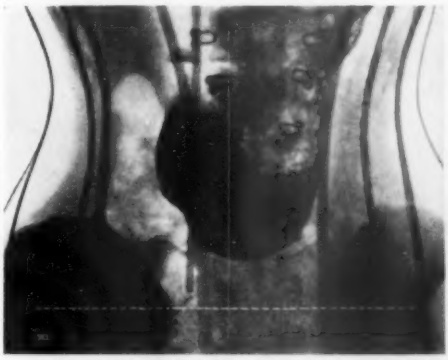
I have been with my set-up 5½ years, and each day is absorbing. All the employees, from the president down to the

X-ray examination shows displacement of internal organs through improper corseting

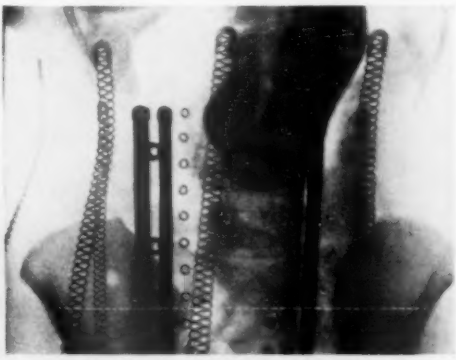
THE unretouched X-ray photographs below tell the story of the effects of the currently fashionable wasp-waist corset as against the Spirella garment.

Spirella corsets are designed to support the figure from the groin line upward, thus aiding natural muscular action. The dotted line drawn between the two anterior points of the crests of the hips demonstrates readily the shift in position of internal organs that occurs when the two different types of garments are worn.

Effect on the Stomach

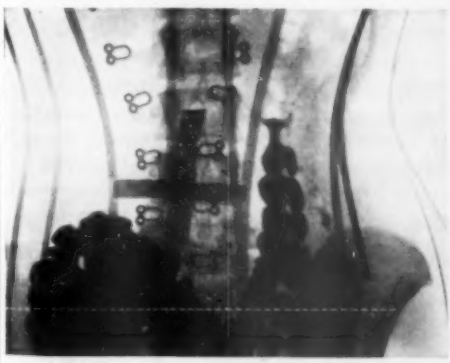


In this individual when the wasp-waist corset is in place, the lower border of the stomach is at a level about an inch above the dotted line. From this we see that the wasp-waist corset depresses the stomach about three inches. The left border of the stomach is situated about two inches from the center of the body.

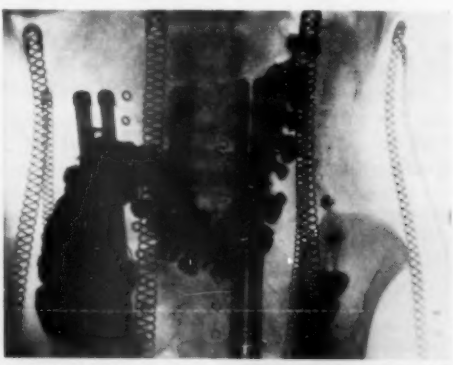


In the same individual with the Spirella corset in place the lower border of the stomach is at a level four inches above the dotted line. The left border of the stomach is situated a little over two inches from the center of the body. From this we see that the Spirella corset markedly elevates the stomach and produces very little lateral pressure.

Effect on the large bowel



With the wasp-waist corset in place on the same individual, the lower border of the large bowel is depressed to a level about two inches below the dotted line. It thus produces considerable pressure upon the large bowel in the lower abdomen.



With the Spirella corset in place, the large bowel is elevated to a level approximately one inch above the dotted line. This indicates that the Spirella corset is giving excellent support to the organs in the lower abdomen, as well as to the stomach.

Literature describing the complete Spirella service is available on request. Write the Spirella Company, Inc., Dept. 5-S, Niagara Falls, N. Y., or in Canada, Niagara Falls, Ontario.

janitors and elevator boys, receive nursing care for illness or accidents.

Will you advise me how to secure information from the National Safety Council?

R.N., Spokane, Wash.

[*The National Safety Council, 20 North Wacker Drive, Chicago, Ill., is glad to assist industrial nurses in planning safety drives. As the Council's program plans change from month to month, readers are urged to write direct to Chicago headquarters for up-to-date information.*—THE EDITORS]

SICK BENEFITS

Dear Editor:

In reading my R.N. from cover to cover last month, I was pleased to find the letter from Missoula, Mont., on sick benefits—a subject dear to my heart.

May I briefly tell you what I should like to see done, if possible?

Each State has a registration fee, and a yearly fee to keep the registration active. In California, our State treasury has a large surplus from these funds. Ten or fifteen years ago, we voted $75,000 to the University of California toward establishing a chair of nursing. Later we gave $30,000 more for this purpose. At that time we had a surplus of over $100,000.

I suggested that this could be used, along with individual contributions from nurses and State association dues, to set up a pension fund such as the teachers had. I was informed that while the money belongs to us nurses, and cannot be used for anything else, it could only be voted to public institutions, and not to private groups.

Is there any way in which this money could be applied toward sick benefits? I think each State could use this method to care for its nurses.

Anna S. McKenna, R.N.
San Diego, Calif.

[R.N. *is investigating this point, will report in an early issue. Meanwhile, readers having information or ideas on sick-benefit plans are invited to send them in. Five dollars will be paid for each usable idea.*—THE EDITORS]

RESPONSE

Dear Editor:

I would like to thank all the nurses who so kindly and generously answered my call for cards in your October issue.

I received several hundred beautiful cards and I do appreciate them. I'm doubly proud because "the nurses" sent them. . .

To get things done, use "Calling All Nurses."

Anna Puler, R.N.
Salisbury, N.C.

R.N.'s BABY

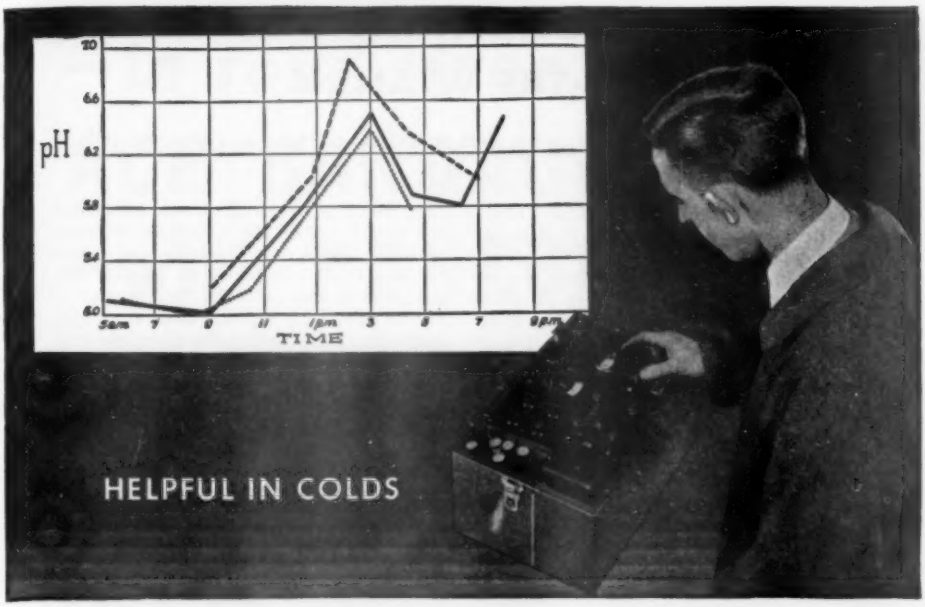
Dear Editor:

May I have an extra copy of the picture which appears on the cover of R.N. for January?

I'd like to frame this, but do not wish to deface my copy of the magazine by tearing off the cover.

Margaret McGregor, R.N.
St. Paul, Minn.

[*If enough readers are interested, it may be possible to offer a limited number of reprints suitable for framing. Would readers like this service?*—THE EDITORS]



ALKALINIZING ABILITY OF

SAL HEPATICA

CLINICALLY DEMONSTRATED

Clinical studies have recently shown that a half teaspoonful of Sal Hepatica two or three times a day tends to raise the urinary pH and keep this higher alkaline level throughout the day. Such alkalinizing properties should be of interest in regard to possible strengthening of resistance in common colds and other conditions where a reaction shift of body fluids towards the acid side may occur.

GENTLE LAXATION THROUGH LIQUID BULK

Chiefly, however, Sal Hepatica is a good laxative, gently yet thoroughly serving to rid the intestines of harmful waste . . . through liquid bulk of the saline solution. Sal Hepatica makes a pleasing effervescent drink and helps to combat excessive gastric acidity and to promote increased flow of bile.

SAMPLES AND LITERATURE YOURS FOR THE ASKING

Sal Hepatica Flushes the Intestinal Tract and Aids Nature Toward Re-establishing a Normal Alkaline Reserve.

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METHODS FOR QUANTITATIVE ESTIMATION OF THE VITAMINS

VI. Measurement of the P-P Factor (Nicotinic Acid)

• Early investigations by the U.S. Public Health Service demonstrated that pellagra may be prevented or cured by dietary regulation. Human subjects confined to an institutional diet known to produce pellagra, were completely protected from this disease by proper supplementation of the institutional diet (1). Ultimately, the existence of the P-P or Pellagra-Preventive factor was established (2).

From the similarity in natural distribution of the dietary factors effective in the control of human pellagra and canine blacktongue—as well as the pathology of these two diseases—the working hypothesis that canine blacktongue is the analogue of human pellagra was adopted (2). Techniques (2, 3) were devised for estimating the pellagra-preventive value of foods by feeding tests with dogs and the results checked by clinical observations with human subjects. The ability of a food to supplement basal diets—known to produce canine blacktongue or human pellagra—so as to prevent or delay the development of characteristic symptoms were the criteria employed for judging the P-P values of foods. Such tests using dogs or human subjects are still the most reliable methods for measuring the P-P potencies of foods (4, 5).

Although pellagra-producing diets may frequently be deficient in a number of essential nutrients (4, 6), the value of nicotinic acid or nicotinic acid amide for the treatment of the specific symptoms of blacktongue or pellagra is well established (7, 8). Recognition of the importance of nicotinic acid in human nutrition created a definite need for rapid methods of estimating the nicotinic acid content of foods. The possibilities of the reaction between nicotinic acid, cyanogen bromide and aromatic amines as a basis of a colorimetric method for estimating nicotinic acid are receiving consideration (9). However, cyanogen bromide and aromatic amines may react with a number of compounds containing the pyridine ring to produce a yellowish green color. Therefore, it is essential that the specificity of any method for nicotinic acid be clearly established before nicotinic acid values determined by the method can be accepted as indicative of the pellagra-preventive values of foods.

Permanent control of endemic pellagra will require inclusion of a larger number of the protective foods in the pellagrin's diet (4, 6). General improvement of diets by this means will serve to correct not only deficiencies of the P-P factor, but of other essential factors, as well. The value of commercially canned foods in a program designed to correct pellagra —as well as its attendant or secondary dietary deficiencies — might well be emphasized.

AMERICAN CAN COMPANY
230 Park Avenue, New York, N. Y.

(1) 1915. U. S. Pub. Health Reports 30, 3117.
1923. Ibid 38, 2361.
(2) 1926. U. S. Pub. Health Reports 41, 297.
(3) 1928. U. S. Pub. Health Reports 43, 657.
(4) 1939. The Vitamins: A Symposium, page 297, Amer. Med. Assn., Chicago.
(5) 1934. U. S. Pub. Health Reports 49, 754.
(6) 1939. J. Am. Med. Assoc. 112, 2581.
1938. Ibid. 110, 1081.
1939. Am. J. Digestive Diseases 5, 807.
(7) 1937. J. Am. Chem. Soc. 59, 1767.
1938. J. Nutrition 16, 355.
(8) 1937. J. Am. Med. Assoc. 109, 2054.
1938. Ibid. 110, 622.
(9) 1938. Nature 141, 830.
1939. Biochem. J. 33, 264.

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Tuberculosis
— nursing's unsolved riddle

[THE EDITORS *realize this is a controversial subject. Readers, as well as medical authorities, will undoubtedly disagree as to the relationship of the positive tuberculin reaction to clinical tuberculosis. But few will deny that this disease is a serious threat to the health of young nurses. If it were not, such experts as Myers, Geer, Jacobs, Boynton, and others would not be constantly probing to find why incidence is so high and what remedial steps should be taken. This article, the first of two on the same subject, is not intended to frighten nurses now in tuberculosis service nor to discourage other nurses from entering that field. Its object is to point out that particular precautions are needed, to urge nurses to seek protection against a disease to which they are continually exposed.*]

• Remember Jessie Jones? Maybe you don't—but you knew someone like her in nursing school. Eager, ambitious Jessie, who everyone agreed would really "go places" in nursing.

She started out by electing tuberculosis service as a career because, as she said, it challenged her ability as a nurse. When her family objected, Jessie laughed at their fears. Why, everyone in nursing knew a tuberculosis hospital was the safest place in the world to work. . .less chance of picking up an infection there than in a general hospital. She had never been sick a day.

No one heard from Jessie for a long while after that. Then, the other day, Rita, her old room-mate, got a letter. The heading—"Valley View Sanatorium"—gave her a shock. The contents were worse.

"Dear Ri," the letter read. "Well, it has happened. I have tuberculosis. I had been tired a long time. But one morning last week I expectorated blood. Three days later I had a slight hemorrhage. So now I am a patient instead of a nurse. I try hard, but it is difficult not to become bitter. I miss my work, my family, my friends. And, since I have practically no money, I'm afraid of becoming a burden. I never thought it could happen to me. . ."

The story of Jessie is not fictional. It was taken from the case histories of a prominent physician.

Nor is it an isolated example. Statistics show many Jessies, too many nurses who fall unnecessary victims to tuberculosis.

Jessie's problem is that of every nurse. It has been so recognized since 1818, when Armstrong demonstrated the high incidence of this disease among nurses.

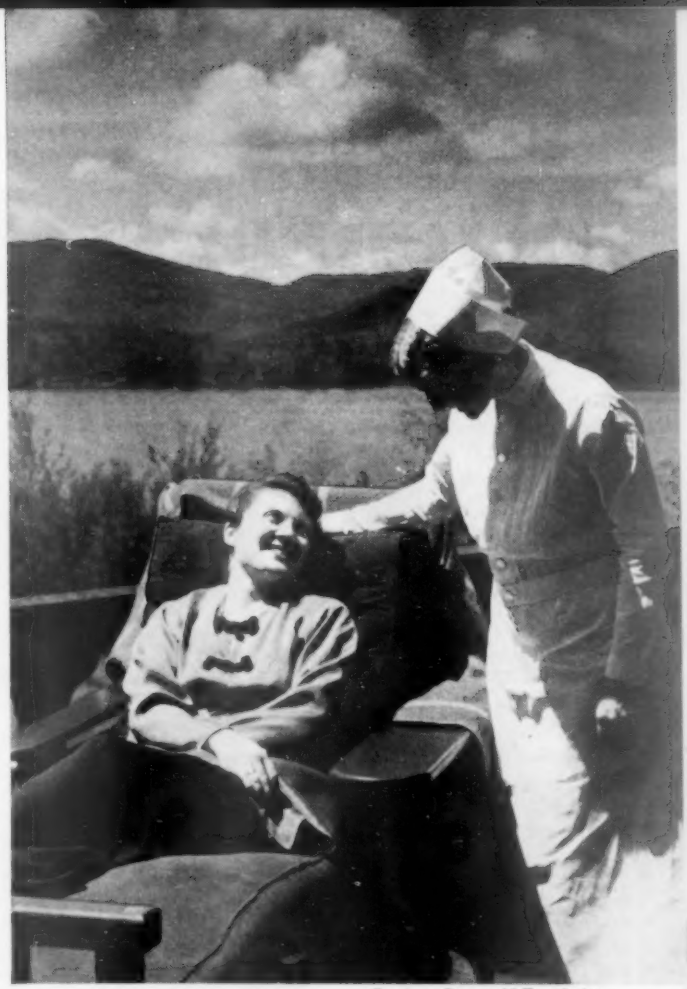
But it is still unsolved.

Proof of its existence today is overwhelming. The scientific evidence would fill a good-sized library. Here are just a few samples:

"Most evidence points to much higher incidence of tuberculosis in the nursing group. . ."[1]

"The tuberculosis infection rate [positive tuberculin reaction] is 100 times

ARTHUR J. GEIGER



Courtesy, Stonywold Foundation

greater in the student nurses on a general hospital service than in students in the College of Education, and 500 times greater in student nurses on a special tuberculosis service than in College of Education students..."[1]

"In hospitals with required tuberculosis service, the incidence of infections as demonstrated by the Mantoux test is practically 100 per cent at the end of three years' training, somewhat lower in those hospitals where contact with tuberculosis is only occasional. In the Minnesota School of Education, among students who had no known exposure to tuberculosis, the increase in positive reactors was only 4 per cent in four years. The highly infectious nature of active tuberculosis is apparent from these figures . . . Every precaution for prevention of transference of the tubercle bacilli from patient to nurse must be taken."[2]

"A nurse with a negative tuberculin reaction coming into a tuberculosis sanatorium is usually likely to develop a positive reaction within six months or less. . ."[3]

"For the pupil, institutional, and public-health nurse, tuberculosis may be an occupational disease. . ."[4]

"The incidence among nurses is a third higher than among women of the same age in the general population. . ."[5]

"Danger to nursing staffs is genuine. . ."[6]

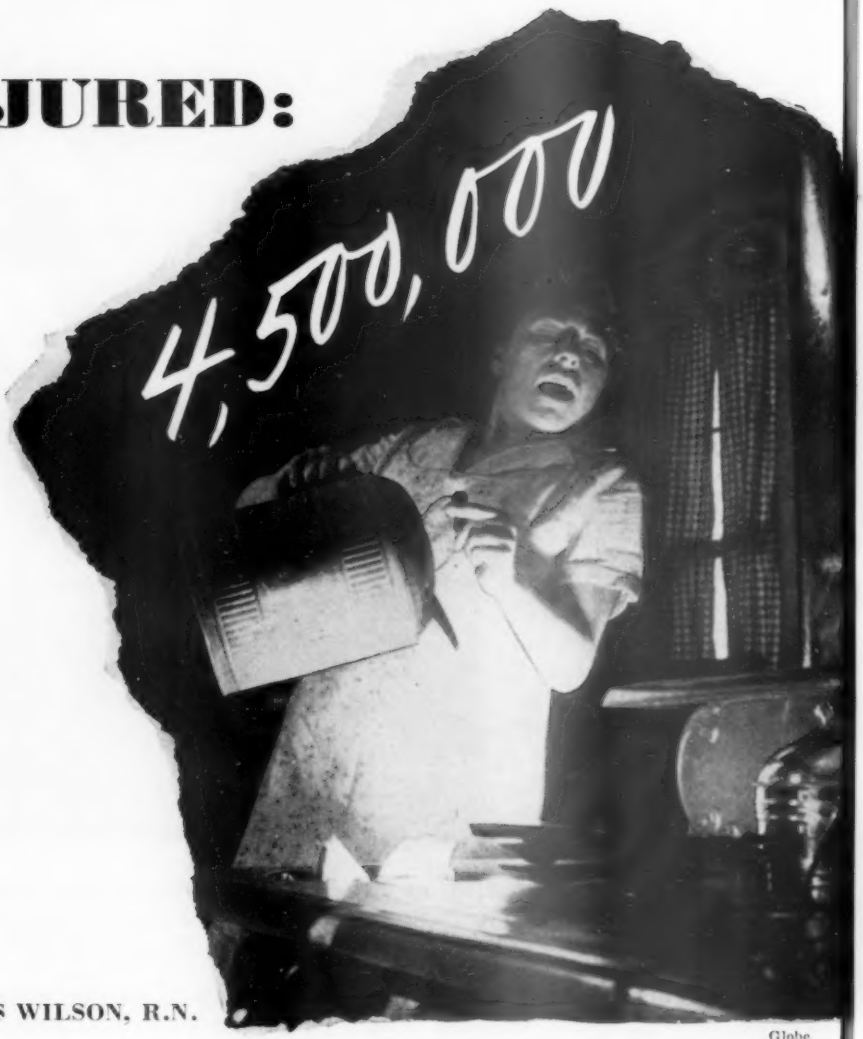
"Students of nursing become infected with tubercle bacilli at a rate no less than in the general population a century ago. . ."[7]

In the face of these warnings, repeated a thousand-fold by the medical profession, what has been done in the way of prevention?

Comparatively little.

Again, not for lack of medical guidance. The American Hospital Association, a few years ago, appointed a committee to probe this problem, as it concerned general hospitals. The committee reported: [*Continued on page* 22]

INJURED:



BY LOIS WILSON, R.N.

Globe

• In the so-called "safety" of their homes, last year, more than 4,500,000 people were injured . . . Some 32,000 met death.

There were, in fact, almost as many fatal home accidents as motor-vehicle fatalities, more accident casualties in homes than in all the nation's industrial plants put together.

Surveys by the Safety Research Institute prove that while the battle is being won on other fronts it is being lost on the "home" front. In the years 1937 and 1938, motor vehicle fatalities were reduced 10 per cent; industrial accidents dropped 11 per cent; and all other public accidents were lowered 8 per cent. But, during the same period, home accidents rose 2 per cent to take first place over all other accidental death rates.

This staggering total of injured and

dead cost the United States $600,000,000 in lost wages, medical expenses, and insurance. And yet, according to the National Safety Council which reported the figure, almost all of these accidents were preventable.

While workers and motorists are being protected by safety campaigns, home campaigns are not producing results.

For each private and public-health nurse, there is a challenge in this extravagant waste of life and money. Safety consultants, in fact, pin a large portion of their hopes on her influence as a safety salesman in the nation's homes. Every time she goes into a home to give nursing care, they say, she has a chance to campaign for safety. Each home case offers an opportunity to pull down the toll of home accidents to a more normal level.

But how can the nurse go about setting herself up as home safety consultant?

Safety experts at the Red Cross, the National Safety Council, and the Safety Research Institute agree that her first step is to become familiar with the chief danger points in every home. Her next step is to find some tactful means of bringing these hazards to the attention of the family. And third, to see to it—before she leaves the case—that some improvement is made and that the family fully understands why.

According to surveys made by safety organizations, the chief danger points in every home are, in this order, stairs; yard; kitchen; dining and living rooms; porch; bedroom; bathroom.

Nurses can help reduce the high toll of home accidents, say safety experts. But it means studying household hazards—campaigning for safety—on each home case. Here's an article which tells how it can be done.

Falls and fires, say the experts, are the two most recurrent types of home injuries. They point to a recent study by the National Safety Council as a graphic example.

Of 4,000 home injuries investigated in Chicago, the council found that 63 per cent were caused by falls, about 10 per cent by fires. When the reasons for these accidents were analyzed, poor judgment, ignorance, hurry, and drunkenness were found to lead the list. Chief household offenders were rickety or cluttered stairs, slipping rugs, careless kitchen arrangements, poor electrical equipment, littered rubbish.

For a cross-section of innocent carelessness which resulted in serious injuries, examine a few actual cases:

Mrs. Brady left her kitchen floor wet when she went to answer her doorbell. Mrs. di Rocci placed the baby's high-chair too close to the stove and a steaming pot of spaghetti. Jed Hogan forgot to tack down the linoleum on the bathroom floor. Michael forgot to put his razor on a shelf Jimmy couldn't reach. Mary Rajeski poured kerosene onto the embers in her coal stove. Muriel Wright stood on the arm of a chair when she hung her curtains. Mrs. Potter's maid waxed the floors to a high gloss and then flung a scatter rug at the foot of the stairs. Joe Miller tried to light his oil furnace with a wad of burning newspaper. . .

These are just a few examples, taken at random from actual records.

There are literally thousands of such incidents on file in cities and towns throughout the United States; most of them resulted in serious injuries, many in death.

Home accidents such as these are not necessarily confined to the poor, the underprivileged, the uneducated. They are found with [*Continued on page* 32]

Dear old golden rule days*

By ROXANN

• "Monotonous?" Marian Hall, R.N., C.P.H., looked at me pityingly. "Of course, if it's monotonous to have regular hours and salary checks instead of the uncertainty of private cases..."

"No, no!" I protested. "I mean the routine. Same thing day after day."

"Same thing day after day?" Marian parroted. "Listen, pal, ease yourself into a comfortable chair while I tell you about the life and times of a nurse in the school-health service." She grabbed up a handful of papers. "I was just starting to make out my day's report. I've plenty of ammunition and you're going to get both barrels.

"First of all, you should see me when I arrive at my little nest in the senior high school at 8 A.M. This morning," she checked each item off on her fingers, "I had a notebook, a purse, a typewriter, a pot of African violets, and Keyte's 'How to Supervise.'

"Tony had fallen off a swing. I hoped his arm wasn't fractured..."

"I opened the door to find Barbara Dunn dripping blood all over my office. Barbara's gang formed a sympathetic back-drop. She had, they informed me noisily, fallen off her bicycle. Her knee was in bad shape. So I cleaned and bandaged it and shooed the sewing circle off to their classes.

"A few minutes later," she went on, "the usual morning epidemic of high-school boys started. That's one type of case you *can* call monotonous—the puppy-love cases. Adolescents who feel that Older Women understand them! I understand them so well I can clear them out of my office in record time."

"And then what?" I asked.

"Well, this morning I had just finished tossing them out when young Mattie Carothers barged in. Mattie invariably gets a severe headache when exams begin. I did a little snooping and found that at 9:30 Mattie was supposed to be telling Teacher all about Caesar's doings in Gaul. So I invited her to come back—after the exam."

"Don't you have to go to other schools, too?" I asked.

"Certainly. At ten o'clock I grabbed some of my impedimenta and dashed across the street for a cup of coffee.

"I got to Larch School at 10:15 and found another officeful of grief. Tony Asandro had fallen off a swing. I hoped his arm wasn't fractured, although it looked suspiciously as if it might be. I hung his arm in a sling.

*Thanks to Mary Owston, R.N.

"I took time out for a liver sandwich at the drug store . . ."

piled him in the car, and sped to his home. His mother is seven-months pregnant, which didn't improve her Latin temperament any. So Tony and I hopped down to the Medical Center for an X-ray. The bone *was* broken; I helped put on the cast and took him home again.

"By this time I was overdue at Alder School, but luck was with me: the list of three-day unexplained absences was very short. I checked up on Carlotta Torres who has just had a skirmish with scabies, and was all set to race along to Willow School, when the phone rang. One of the neighbors reported that Mrs. Sagone had fainted, and I'd better come right away.

"Off I went, buckety-buckety, and found the Sagone place in an uproar. Mrs. Sagone had been washing. So I had to play hop-scotch over piles of clothes, tubs of starch, basins of bluing, and four little Sagones. Mrs. Sagone was really very sick. I called a neighbor to stay while I phoned the doctor and a social service worker."

"It must have been nearly sundown by that time," I murmured.

"Sundown nothing!" said Marian scornfully. "It was about one o'clock. I'd been coasting all morning on a glass of orange juice and a cup of coffee, and I was starving. So I took time out for a special liver sandwich at the corner drug store.

"At Willow School there were four home visits awaiting me. I attended to those and hurried to Spruce, where I had to inspect thirteen children—"

"Reminds me of my misspent youth," I interrupted, "when The Doctor and The Nurse made their rounds and examined us all. How I hated it! The doctor sported a big, black beard that reminded me of Uncle Jonathan. I detested Uncle Jonathan because he used to try to kiss me through a forest of whiskers. I didn't like doctors either, so the doctor had two strikes against him before he even started. It seems to me that they used to ask us to unbutton a few strategic buttons and, since I was a modest kid, I'm afraid the doctor and nurse had a problem on their hands!"

"Children nowadays aren't much different," Marian answered. "From the actions of some of them you'd think we were going [*Continued on page* 37]

"You'd think we were going to shoot them when we try to examine tonsils . . ."

What's in a *Name?*

• From a reader, this month, comes this inquiry:

"I enjoy R.N. But I don't understand how it all came about. The first issue arrived a long time ago. Ever since, the magazine has been coming as regularly as the fifteenth of the month. No one has yet asked me for a donation to any worthy project. Nor for money to support the staff. In this day and age the whole thing seems almost too good to be true. Tell us what's behind your name, R.N.—A JOURNAL FOR NURSES."

We believe that many readers may be asking themselves the same question. So, we'd like to tell you again how it has been possible for us to send you your copy of the journal each month.

R.N. is published by an independent publishing company. It is supported by revenue from its advertising. Because this source of income is sufficient to meet our production costs, there is no subscription charge.

Our editorial department, however, is not controlled by our advertising department; the two are entirely separate, as in all ethical publications. In fact, nothing influences our selection of material *except* the interests and

needs of R.N. readers. We have no ties with any axe-grinding groups or individuals and can, therefore, keep our columns clear of propaganda and prejudice.

Because we are independent, we have been able to bring you such articles as: "Uncle Sam, M.D."; "The War and You"; "Community Nursing—Its Future"; "In Unions there is—?"; and this month, "Tuberculosis—Nursing's Unsolved Riddle." These articles all discussed topics vital to the profession of nursing. Each contained facts important to nurses as individuals. Yet not one could have appeared if R.N.'s editors were obliged to bow to the "approval" or "official endorsement" of self-interest groups.

No. There is no catch. R.N. readers will not be asked to make donations either to the magazine or to unrelated projects. We will not ask you to support the staff—except by telling us, from time to time, what will help you most. We will not ask you to vote a straight ticket, go to war, or join a labor union. We believe *you*—and you alone—can make the important decisions in your life. And as long as R.N. is published we will continue to urge you to do so.

What's behind our name? We like the terse answer of a member of our staff to whom that question was put: "Not A.N.A., not C.I.O., not A.F. of L.—just plain R.N." That's the way it will always be. Just R.N. . . . A journal for nurses.

How to outfit a bag

BY MONA HULL, R.N.

• When I was a visiting nurse, not so long ago, I used to envy my friends in private practice because they didn't have to carry a bag around all day. Then I discovered they envied me because I *had* one.

Since then, I've gone investigating. I've interviewed almost a hundred private-duty nurses. Most of them carry some sort of makeshift kit containing a little equipment. But about eight out of every ten said they would like to have a professionally outfitted bag to take with them on cases. Even patients in better homes, they told me, seldom have all the equipment a nurse really needs when she goes on a case.

"Often," these nurses reported, "we reach a home on a pneumonia call and find that despite the doctor's request the family has secured no rectal tubes, no thermometer, no cotton or alcohol. Eventually, supplies come through from the drugstore. But even a small delay can be dangerous in pneumonia where every moment counts. . .Or, the doctor orders a high colonic and we have to wait until some tubing can be sent in. Or a dressing. . .Ever try to do a dressing without a kelly clamp and bandage scissors?"

R.N. was impressed by this interest. It was decided to outfit an ideal kit which private nurses might use for either hospital or home duty.

In planning equipment for the "ideal bag," three factors were kept in mind: usefulness, economy, good-looks. (See photo on opposite page.)

Here's how we worked it out:

The bag, complete, is really three bags. We recognized that the private nurse would not need as much equipment for hospital cases as she would in homes. So we selected a large, leather outer bag with space for uniform, reading material, knitting, cosmetics, pen and pencil, and other necessities for a night or day at the hospital.

For nurses on home cases, we chose next a smaller equipment case which fits conveniently into the outer bag. In the equipment case there are spaces for these most frequently needed items:

Bandage scissors
Kelly clamp
Forceps
A 2-c.c. syringe with two needles
Rectal thermometer
Oral thermometer
Baby scale
Fountain-pen
Rectal tube
Catheter
Record material

With the exception of the baby scale, you'll find this equipment necessary and useful whatever your case.

Liquids, we decided, always cause trouble in a bag. So the third case was selected because it holds spill-proof bottles. This kit is very much like the leather vial cases which physicians carry. It contains eight 8-ounce bottles in which you may carry such things as green soap, alcohol, hand lotion, amyl acetate (for removing adhesive), and mercurochrome. We saved one of the eight bottles for sterile cotton, and another for toothpick swabs as most nurses say they like to have a supply of these with them.

All three kits are in matching leather—black moose-grain cowhide—with slide fasteners. The large outer kit has a rubber lining which may be thor-

oughly scrubbed at the end of each day on duty. The smaller kits take up very little space in the large bag, permitting ample room for a uniform and other personal equipment.

What about costs?

We did our best to keep these down to rock bottom.

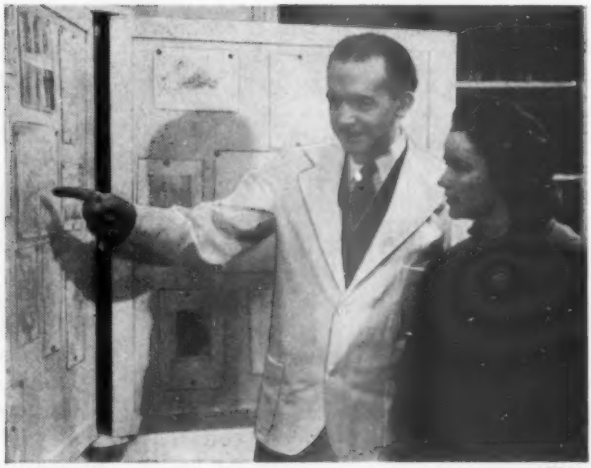
The large, carry-all bag, measuring 5 inches high and 10¾ inches long, can be had for about $5. For the instrument case, partly equipped (containing mouth and rectal thermometers, syringe and needles) the average price is around $7. If you already have syringe and thermometers, you may purchase the case separately for under $4. The vial case, containing eight bottles with Bakelite screw tops, runs around $6.

For nurses who want to outfit the instrument case (as shown in the illustration), here are the lowest figures we could find for reliable equipment:

Bandage scissors	$2.00
Kelly clamps (*very expensive*)	3.00
Straight clamps	2.50
Thumb forceps	1.00
Baby scale	.80
Rectal tube	1.00
Catheter	.25

If you are among those who want a professional [*Continued on page* 36]

Still room for more! When all this equipment is stowed away, the bag will still have space for personal belongings.



Globe

Good prenatal care helps to prevent development of toxemias. Here a physician explains frequent symptoms to a mother-to-be.

Toxemias of Pregnancy

• Pregnancy, although a physiologic episode, may lead to a number of complicating diseases. Because of the metabolic and physical burden imposed upon the parturient, preexisting abnormalities are usually aggravated. If the general health is good at conception, the chances of developing complications during pregnancy are small. Modern prenatal care, which insures a good nutritional state and enables the physician to detect abnormalities at their onset, has reduced morbidity to an extremely low figure. However, despite meticulous attention during pregnancy, morbidity cannot be prevented. The toxemias, due directly to the pregnant state itself, are perhaps the most serious, and are attended by a relatively high mortality rate.

Hyperemesis gravidarum.—A certain degree of nausea and vomiting occurs in more than half of all pregnancies. It is commonly believed that gastric upset always develops in the first trimester of pregnancy. The belief itself is probably responsible to some extent for this disagreeable development. As a general rule, nausea and vomiting occur less frequently in emotionally stable women. Occasionally, pernicious vomiting develops out of the "normal" variety. This may prove fatal if not judiciously treated.

Hyperemesis gravidarum occurs during the first trimester, usually between the seventh and twelfth weeks. It may last as long as three months. Sometimes the condition terminates fatally in two or three weeks. All degrees of severity have been described. Often it is difficult for the attending physician to determine when simple vomiting has lapsed into the more serious form.

Once established, pernicious vomiting becomes progressively more severe. At first, the manifestations of the simple form are exaggerated. Nausea is more severe upon awakening, and breakfast is more frequently followed

by emesis. The appetite is lost entirely; the mere sight or thought of food may cause nausea. At first only liquids are rejected. Later solid food is promptly vomited. Hiccoughs, excessive salivation, thirst, and abdominal pain quickly develop.

As the condition becomes more firmly established, vomiting becomes more frequent and is not related to meal taking. After the gastric contents have been lost, mucus and bile are brought up. Some investigators have reported vomitus with a fecal odor, indicating that the intestinal contents find their way to the stomach to be lost during vomiting seizures.

The almost incessant retching leads to severe irritation of the lining of the throat, esophagus, and stomach. This frequently causes bleeding which may become severe.

The loss of fluids and salt produces marked dehydration, scanty urinary excretion, and marked loss of weight. The pulse is rapid and thready. The patient becomes extremely weak; maniacal or psychotic manifestations may develop.

If the condition is not corrected, death occurs from emaciation, dehydration, and what appears to be a toxemia. Yellow atrophy of the liver with its attendant jaundice may develop and hasten the end.

The cause of pernicious vomiting is not known. Some physicians blame a toxin believed to be liberated by the products of conception. (This toxin has never been isolated.) Others feel that the cause of vomiting is entirely emotional. They relate it to the patient's fear of pregnancy, domestic difficulties, or perhaps to an unplanned pregnancy.

Many remedial measures have been suggested, but none has been completely satisfactory. On these steps, however, all authorities agree:

The patient is removed from the home and placed in a hospital. Visitors are prohibited. The room is darkened, quiet is constantly maintained, and all reference to food is avoided. Dehydration and salt loss are combated by hypodermoclysis or venoclysis. Oral feedings are eliminated for several days. Sedation is effected by rectal administration of bromides or chloral hydrate, or by intravenously administered barbiturates. As soon as the nutritional state is improved, food is given by mouth in small quantities. The diet consists of dry food exclusively. The feedings are small, and are repeated frequently.

Psychotherapy is all important, and can accomplish more than all other measures combined. Kind, sympathetic handling by the physician combined with reassurance has frequently corrected the condition. The nurse in attendance can aid measurably in the psychologic control of the patient.

When all conservative measures fail, pernicious vomiting must be controlled by therapeutic abortion. This procedure usually produces an absolute cure, but must be performed before the patient has become too poor a surgical risk. Curettage is the preferred method for emptying the uterus.

Eclampsia.—Eclampsia usually develops in the last trimester of pregnancy. It is characterized by "evidence of toxemia" and convulsions before, during, or after delivery. The multiplicity of attending symptoms may make the primary pathologic change appear to be nephritic or hypertensive. Severe nephritis, hypertension, or edema may develop in a non-pregnant woman or in a man without ensuing convulsions. During pregnancy, however, these conditions frequently lead to convulsive seizures. Evidently, then, the parturient state produces some change which predisposes to convulsions. Whether this is an alteration in the irritability of the nervous system, or the liberation of a toxin, is not known. [*Turn the page*]

Eclampsia occurs more frequently in primiparas, in older parturients, and in neurotic women. Its incidence is approximately one in 150 pregnancies. Previous toxemias and preexisting liver or kidney disease seem to be predisposing factors.

While most cases reach their climax during the third trimester, many instances of eclampsia during the earlier months have been reported. Statistics differ as to the period when the convulsive seizures are most apt to occur. It is usually stated that about half of all patients develop convulsions during pregnancy. In the other half, the disease culminates with equal frequency during labor and the immediate postpartum period. The maternal and fetal mortality rates are high. About 20 per cent of the patients and about 50 per cent of the infants succumb.

Manifestations of toxemia may develop early or late in pregnancy. Some women may be in a "preeclamptic" state for months without actually developing convulsions. Good prenatal care aids in early detection of the toxemia and is effective in preventing the appearance of convulsions in many patients.

The early symptoms are vague. Headache, dizziness, blurring of the vision, spots before the eyes, muscular twitching, and loss of appetite usually appear first. With time, the blood pressure rises, edema of the ankles and the eyelids develops, the urine becomes scanty and contains albumin, red blood cells, and casts. The pulse becomes rapid, respiration more labored, and generalized edema develops.

This syndrome may be arrested at any stage of its development, and convulsions averted. Such patients usually have a normal delivery. In true eclampsia, however, the condition appears late in pregnancy, and rapidly culminates in convulsive seizures. Edema of the brain is believed to be responsible for the convulsions. Some physicians assert, however, that toxins, arising from the products of conception, produce spasm of the cerebral vessels. This, they claim, is the direct cause of the seizures.

The convulsion itself comes on suddenly. It may be precipitated by jarring of the bed, loud noises, manipulation by physician or nurse, or any other type of mechanical stimulation. The seizures appear with increasing frequency. If untreated, they may develop into a state comparable to *status epilepticus*—a series of frequently recurring convulsions between which the patient remains unconscious.

The individual convulsion consists of a tonic and a clonic phase. The patient loses consciousness and if standing or sitting, falls to the floor. Every muscle in the body contracts. The limbs become rigid, the eyes and head turn to one side, respiration is halted, and the trunk is flexed. In a few seconds the clonic phase begins. The muscles of the trunk and limbs contract spasmodically. Rapid movements of the lower jaw may inflict serious lacerations on the protruded tongue. The pulse becomes rapid, the skin cyanotic, the eyes bulging. Within 30 seconds to 2 minutes the patient relaxes and goes into a comatose state from which she awakens in a few minutes. Fortunately the details of the convulsion are unknown to the patient, although soreness of the muscles and a bewildered mind strongly suggest that something serious has transpired. The extreme force of the muscular contractions may produce fractures. Coincidental elevation in blood pressure may lead to cerebral hemorrhage.

If death is to occur, the seizures increase in frequency and become more severe. The temperature rises and the pulse rate becomes exceedingly rapid. After a large number of convulsions (50 or more) the patient dies of cerebral hemorrhage, cardiac dilatation, or sheer exhaustion. [*Continued on page* 28]

Nutrition Briefs

● Canned milk for children? Grandmother would have thrown up her hands in horror! But recent experiments add solid proof to the theory which nutritionists have offered for years: that evaporated milk is both digestible and nourishing.

Three pre-school children from the Methodist Children's Village in Detroit, were subjects of a recent experiment by the Children's Fund of Michigan, which pointed once more to the excellent qualities in canned milk.

But, in this case, research workers wanted to solve a more difficult problem.

They wanted to discover whether irradiated evaporated milk had any special advantages over plain evaporated milk.

The children were chosen because they lived in a controlled, well-regulated environment. For sixty-five days before the experiment started, they all lived under the same regime, and had the same diet of plain cow's milk.

The experiment was divided into three time periods of twenty-five days each. The children drank plain milk during the first period, evaporated milk during the second period, and irradiated evaporated milk during the third.

During the entire experiment, the growth of soft tissue and bone tissue in the three subjects was carefully checked.

Results were definite and surprising. Evaporated milk proved to be more effective than plain milk in producing soft tissue. Irradiated evaporated milk proved to be more effective than either of the other two forms, in formation of healthy, stable bone tissue.

Another superstition exploded. Or shall we say, "The can is as mighty as the cow!"—*Influence of Fluid and of Evaporated Milk on Metabolism of Growing Children. Amer. Jour. Diseases of Children. Fall 1939.*

● "Is our newer knowledge of nutrition doing us any good?"

That is the question Mr. and Mrs. Public might well ask themselves, in the face of the quantities of food facts hurled at them by chemists and dietitians on every hand. "Is all this information being applied in our daily menus?"

Speaking for the younger generation of the Public Family, the adolescent group, it would appear from recent studies that they still live in the Dark Ages, nutritionally speaking. They choose their foods as if the vitamin were still undiscovered, and the calorie still an unknown element.

A recent experiment on the adolescent diet was set up to include girls of high school age from typical middle-class families. The problem of economics was thus ruled out. These daughters of substantial

citizens *could* have a well-rounded diet if they chose.

To quote the old ballad, "This is what they ate": Spaghetti, white bread, desserts, and candy. Of course, they ate other things too. But [*Continued on page* 48]

Tuberculosis

[*Continued from page* 9]

"Only from 15 to 25 per cent of the nation's general hospitals attempt to protect nurses from this disease."

Attributing this to lack of knowledge, the committee outlined a model hospital program. It called for recognition of symptoms among *all* admitted patients; observance of precautions during diagnosis; custody of known cases; repeated checks on the status of staff members, including nurses.

Not a general hospital in the country is believed to have taken the committee's advice.

Why?

The chief reason, nurses report, is the cost. But hospital heads are inclined to discount this.

From one source comes this argument: "Nurses will become positive (tuberculin) reactors sooner or later. The sooner, the better. If it happens while they are students, they may build up an immunity."

Chest specialists explode this theory.

"Such reasoning," they say, "is highly dangerous. It might apply to diseases with a fixed incubation period—like diphtheria. But not to tuberculosis. Most nurses contracting this disease don't become ill until months—or years—after training. That's when its real effect is felt. In fact, the sooner the nurse is infected, the sooner she becomes a potential clinical case."

Many hospitals affect an "it-can't-happen-here" attitude. Elsewhere, perhaps. But "not here" because—they explain—"We don't admit tuberculosis cases."

What they mean, physicians append, is that they don't *knowingly* admit such patients. Medical men are practically unanimous that tuberculosis is streaming into general hospitals in the guise of other diagnoses.

This contention is confirmed by a recent New York State Department of Health study. Chest films were made

Enriched in these 7 Vital Elements!

Three daily servings of Ovaltine, made with milk according to directions, supplies the following amounts of these food essentials:

Vitamin A
2625 units (USP X1)

Vitamin B_1
297 units (Internat'l)

Vitamin D
316 units (USP X1)

Vitamin G
488 units (Sherman-Bourquin)

Calcium
One gram

Phosphorus
918 milligrams

Iron
8.7 milligrams

. . . thus supplying the minimum daily requirements of Vitamins B_1 and D, Calcium and Phosphorus, and from a half to three-fourths of all the Vitamins A and G, Iron and Copper the average person needs for health.

The New, Improved OVALTINE is designed to supplement the diet with food factors most apt to be lacking . . . Has other important properties, too!

THERE is increasing evidence that so-called "average" diets often are deficient in one or more of the important vitamins or minerals.

In the light of this new scientific knowledge, Ovaltine has been enriched with standardized, added amounts of four essential vitamins and three essential minerals. Always a source of these seven food elements, Ovaltine has been fortified to make it a still richer food supplement.

Thus—more than ever before—Ovaltine helps to fill "gaps" known to exist in the American dietary. *It is designed to supplement the diet especially in those elements most apt to be lacking.*

Equally important, Ovaltine supplies quality proteins, quickly-absorbable carbohydrates and emulsified fats. It makes milk more digestible. It helps digest starches, as shown by tests in vitro and in vivo.

Ovaltine is consequently a valuable "protecting" food-drink for patients of all ages who need "building up."

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The new Ovaltine comes in two forms—plain, and sweetened Chocolate Flavored—virtually identical in nutritional value.

The New, Improved OVALTINE

of 4,000 patients in general hospitals. Forty were discovered to be active pulmonary cases. In seven of every ten of these instances, the infection was unknown to the hospital.

Federal surveys cast additional light on this situation. Tuberculosis mortality in the nation, they indicate, is higher in general hospitals than in tuberculosis sanatoria.

Many doctors believe that hospitals have the wrong slant on the economics of prevention.

"Of course," they assent, "tuberculosis control costs money. So does everything worthwhile. The real question is: Would not these expenditures be cheaper in the end than the present waste of nurses' lives and health?"

Their answer is that such an investment will repay any hospital in increased nursing efficiency.

To insure the nurse's safety in a general hospital, the National Tuberculosis Association urges adoption of the following *minimum* standards:

1. Physical examinations, *plus* tuberculin tests and chest X rays, for all nursing school candidates.

2. X-ray re-examination of students every six months; of those with chest pathology, every three months.

3. Instruction of nurses in personal anti-tuberculosis hygiene.

4. Chest X rays of all maternity patients, as well as other patients with infectious or chronic coughs.

For nurses in tuberculosis divisions or sanatoria, they would add:

1. Every possible sanitary device, including sufficient washrooms, masks, and gowns.

2. Insistence that patients observe regulations designed to safeguard the nurse.

3. Extra-good working hours, living conditions, and recreational opportunities.

4. Restriction of tuberculosis service to those with special training.

Do such programs pay dividends?

Dependable Germicidal Activity *with a high therapeutic ratio*

CLINICALLY, the physician selects therapeutic and prophylactic preparations which do not interfere with normal physiology. In the field of antiseptics, on the basis of germ-killing action and tissue toxicity, Hexylresorcinol 'Solution S.T. 37' is probably the safest and most effective antiseptic available for clinical use.

All recognized standard methods for testing germicides demonstrate the germicidal activity of Hexylresorcinol 'Solution S.T. 37.' It is germicidal in the presence of serum, blood and organic matter. It is germicidal in dilution with four or five parts of water.

Hexylresorcinol 'Solution S.T. 37' is soothing to inflamed tissues by exerting a local surface analgesic effect. It is non-toxic, non-irritating, stainless and odorless. Its low surface tension aids penetration of the germicide into minute tissue crevices. It is *not* a mercurial antiseptic.

In convenient 5-ounce and 12-ounce bottles.

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PHILADELPHIA

Wisconsin General Hospital is a case in point.

At this institution, students have an eight-hour day. Four to six of these hours are spent on the ward. Their status is regularly checked by tuberculin and X-ray tests. Although exposed to a T.B. ward during training, the percentage of positive reactors among these students increased but ten per cent in three years! Not an active case was reported in five years!

Contrast this with a school having a tuberculosis section but no preventive measures. Its ratio of positive reactors rose from 30 per cent at entrance to over 95 per cent at graduation!

The Council on Professional Practice of the American Hospital Association is a strong supporter of systematic prophylaxis. It can reduce the tuberculosis incidence among nurses, the Council predicts, to below that for women in other occupations.

As yet, however, American Medical Association figures show that such programs are neither complete nor widespread. Only 75 per cent of general hospitals with tuberculosis departments even examine their nurses, a test study of average hospitals reveals; only 60 per cent take chest X rays; and but 30 per cent make tuberculosis surveys.

And prevention is only half the problem. What about those nurses who develop into chronic cases? Where are they to obtain the expensive treatment that a long illness may require?

The majority of hospital and nursing officials soft-pedal any intimations that adequate care is not available to all nurses. Nursing organizations, they point out, will advise afflicted nurses.

But, in the opinion of many nurses, something more than advice is needed.

As it is, the nurse can usually get all of this commodity she requires from her doctor. The latter is usually glad to place diagnostic facilities at her disposal; either without fee or at "professional rates." [*Turn the page*]

CLEAR THE WAY FOR RELIEF IN MUSCULAR ACHES AND PAINS

MINIT-RUB acts quickly to help clear local congestion, by speedy action on the unbroken skin for relief from muscular aches, sprains and pains. Rubefacient and counterirritant, MINIT-RUB helps normalize local metabolic processes by dilation of capillaries . . . to improve circulation . . . to aid in tissue rehabilitation.

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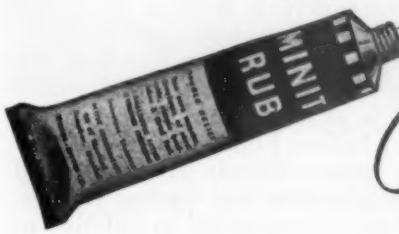

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When it comes to securing extended hospitalization, however, it is a different story. Nursing's tuberculosis riddle becomes even more complex.

Unlike other people, nurses have great difficulty securing health insurance. Unlike other people, most nurses are unable to pile up savings against possible future illness. Moreover, nurses prefer not to accept charity. The problem of finding adequate hospitalization and treatment sufficient for full recovery is, therefore, acute.

[*Next month Mr. Geiger sums up his investigation, discusses some possible solutions.*—THE EDITORS]

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Toxemias

[*Continued from page* 20]

The treatment of eclampsia begins before the toxemia develops; that is, every pregnant woman should be considered a possible candidate, and should be watched for signs of impending toxemia. As soon as the preeclamptic symptoms develop, bed rest is advised. An easily digested sustaining diet is prescribed to reduce the load of the heart, kidneys, and liver. All voided urine is examined for indications of kidney failure. Fluids and dextrose are given subcutaneously if nausea and vomiting prevent oral feeding. A quiet, darkened sickroom and prohibition of

"SARÁKA Was NO SECRET to Doctors I Talked to at The World's Fair Exhibit."

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Yes, doctors appreciate the bland smoothly-gliding *bulk* (often lacking in the average daily diet) provided by Saráka. They like the way Saráka "exercises" lazy intestinal muscles to help reestablish natural peristaltic *motility* and rhythm. No griping, straining, digestive upsets or annoying leakage.

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visitors reduce external stimulation. This regimen frequently halts the progress of the toxemia and may enable the patient to deliver without developing convulsions. Most authorities agree that labor should be induced, since emptying the uterus is usually followed by rapid recovery. Rupture of the membranes or insertion of a bag are the methods of choice.

When the eclamptic state has fully developed and convulsions appear with increasing frequency, therapeutic measures must be instituted at once. However, marked difference of opinion exists as to the type of treatment. One group feels that conservative measures produce the lowest maternal mortality rate, while the other school insists that radical steps—immediate termination of pregnancy—yield superior results. The consensus, however, favors the former group.

Conservative therapy consists of the use of sedative drugs. The popular Stroganoff method calls for alternate doses of morphine sulfate hypodermically and chloral hydrate rectally. Other writers recommend injectable barbiturates. During the period of induced narcosis, fluids and dextrose are given parenterally. Labor may develop spontaneously; usually the fetus dies in utero. If labor does not develop, induction by means of a bag is employed.

During the convulsion the patient should be carefully watched. Injury to the tongue is prevented by inserting a clothes pin or a wooden peg between the teeth. Restraint is not advisable as it may increase the incidence of fractures. False teeth are removed and no medications are given by mouth in order to prevent aspiration. A darkened room, absolute quiet, and a minimum of manipulation reduce the frequency of the seizures.

[*For a bibliography of the procedures discussed in this article, send a stamped, addressed envelope.*—THE EDITORS]

Injured: 4,500,000

[*Continued from page* 11]

surprising frequency in middle and upper-income homes. Proving, say safety engineers, that a débutante and a dime-store clerk can be equally careless when it comes to avoiding home accidents.

That is one reason why consultants see in the nurse a logical crusader for safer homes. She cares for the rich and the poor alike. Families respect her opinion and follow her advice. So, she can spot the hazards in each particular home situation and tactfully make recommendations.

Most authorities say that the most practical way of doing this is to develop the habit of observing home surroundings with a clinical eye. "It's not enough," they point out, "to hover over your patient and talk to him about the theories of home safety. That is just preaching and no human being—much less a sick one—wants to listen to that. You must spot a few possible hazards and, when suitable opportunity arises, mention simple ways of eliminating them. You can make your suggestions sound as though you *knew* the patient would have thought of this herself... if she were well, and had a little more time."

Here are a few suggestions which nurses might make as a result of observing possible household hazards:

See that all stairs are provided with rails and adequate lighting.

Avoid placing loose rugs at the foot of stairs or at turns.

Don't let loose articles clutter up steps.

Never use chairs or other unsafe substitutes in place of ladders.

Be sure there is a handhold in the bathtub.

Always keep a fire extinguisher in the house.

Use safety matches and keep them away from children. [*Turn the page*]

MANY A DOCTOR SAYS that nothing takes the place of cod liver oil in helping children develop sturdy frames and sound teeth.

YET, AS A NURSE, you've experienced difficulty in getting children to take cod liver oil. Many of them dislike its taste. It makes others regurgitate. If you have such patients, recommend the BETTER—MORE PALATABLE—WAY TO TAKE COD LIVER OIL . . . SCOTT'S EMULSION!

1—Scott's Emulsion has *all* the values of cod liver oil and is four times more easily digested.

2—Easily Digested—The exclusive method of emulsifying the oil permits digestion to start in the stomach, whereas digestion of plain cod liver oil does not begin until the oil passes into the intestines.

3—Easy to take—Scott's Emulsion has a pleasant taste. Easy to take and retain by children and adults.

4—Economical—Scott's Emulsion is an economical way to obtain the Vitamins A and D so necessary to strong bones and sound teeth.

SCOTT'S EMULSION

Open all doors of the oven to ventilate it before lighting.

Always set electric irons on a non-inflammable stand.

Place a screen before an open fireplace.

Don't accumulate rubbish in attic, basement, or closets.

Keep oiled rugs and mops in a proper container.

See that the frame of an electrical washing machine is properly grounded.

Discard all frayed electric cords.

Equip outdoor radio antennae with lightning arresters.

Keep poisonous drugs out of the reach of children.

Put small bells on poison bottles to warn the groper-in-the-dark.

Never run the automobile engine in a closed garage.

Conduct a family conference on safety precautions from time to time.

Not all these points will apply, of course, in the case of all patients. They do illustrate, however, the kinds of hazards for which the nurse can be on the lookout. She can make recommendations about these hazards logically and without causing the patient to suspect she is not tending to her own business—nursing.

How is the nurse to see that some steps to eliminate the safety hazard are taken before she leaves the case?

Experience has shown that no general rules can be applied to all cases. Each family is a different problem, every home situation demands a different technique. One method which has proven successful is to encourage members of the family to take part in community-safety drives. Another is to urge them to read safety literature, to write to the National Safety Council in Chicago for up-to-date information. [Nurses and patients both should find valuable data in two recent publications of the council, "Accident Facts," and "Hurt at Home."]

Perhaps the soundest advice, how-

ever, is that of a Midwestern safety engineer who said:

"If nurses can do no more than encourage an intelligent awareness to safety hazards in the home they will be doing the nation's health a vast service. One of the most important steps in reducing the incidence of home accidents is to see that families do not become 'accident conscious' instead of safety conscious. Nurses, with their understanding of human nature, are the logical people to do this. Whatever happens, we don't want the public to become *frightened* by the high chance for accidents in the average home. That would only cause more injuries."

There is a vast new field of action for nurses in the current home-safety movement, says Leonard Maar, consultant for the Safety Research Institute in New York. "It is easy for councils and institutes to reach the industrialist and the executive. But when it comes to the home, we must enlist the aid of those who know families. Obviously, the registered nurse is one of the few scientifically trained workers who fit this requirement."

He and other safety authorities agree that nurses should assume some of the responsibility for educating families in accident prevention. If they do, the country's home-safety record should be noticeably improved within a very short time.

How to outfit a bag

[*Continued from page* 17]

bag, but feel that purchasing one complete with all equipment would be too much of a blow to the budget, maybe you can work it out as one of our readers did.

"Ten dollars for instruments," she reports, "was more than I could manage all at one time. So I asked my family and friends to put me down for scissors and clamps for my birthday

this year. Well, that day came along last month and I fell heir to a new fountain-pen and a twin-set of thermometers as well."

Another stunt you might try is to budget your funds to allow for one new piece of equipment each month. In less than a year you should have the complete outfit put together—and without any particular strain on the pocketbook.

The total cost, however, is not exorbitant. For the entire outfit, including equipment, about $30. For the three kits with partial equipment, around $18.

Golden rule days

[*Continued from page* 13]

to shoot them when we clap a stethoscope on them, or try to examine their teeth and tonsils. Thank goodness I didn't have any examinations slated for the last school on the list today. All I did was to add the names of two three-day absentees to my list, and admire the gold-star teeth chart in Miss Perkins' room.

"The clock had spun around to two o'clock and at 2:30 I had to lecture on sex hygiene at the senior high school. My twenty-six sophomores are supposed to be learning the facts of life from me, but from the expressions on some of the faces I wonder . . .

"Well, after I left the classroom I had an hour's conference with the principal, Mrs. Wilson, about a truancy case. I got back here at six, grabbed dinner and a tub, and started my reports as you came in."

She glanced at the clock. It was 7:30. "Heavens, is it *that* late? I'll just have time to dress before Jim gets here. We're going night-clubbing—just to get away from the monotony," she said.

"You've *got* something there," said I, feeling by this time I could do with a change myself!

Calling all nurses

Is there someone in the profession you'd like to locate? You may insert here, without charge, a 75-word notice. Items will be published in the order received. Be sure to include your full name and address so that replies may reach you. Just address the "Calling all nurses" editor.

MARIE THOMAS: Important information is being held for you at this office. Will you communicate with us as soon as possible? "Calling All Nurses" Editor, R.N.—A JOURNAL FOR NURSES, Rutherford, N.J.

HELEN MARIE SHIELDS: St. Anthony's graduate, Class of 1932, Denver. Dear Helen: Where are you? I'm so anxious to hear from you and other St. Anthony's grads. Would like to send you a copy of our alumnae paper, The Mascot. Mary G. Ferguson, 1611 Wolff St., Denver, Col.

ALL NURSES: My hobby is collecting nurses' caps from all nursing schools in the United States and foreign countries. I'd be so honored to receive one of your old caps with a brief history of your training school. Gladys Fidler Martin, 2780 Twenty-third St., San Francisco, Calif.

AIR AND TRAIN STEWARDESSES: I collect pictures of nurse-stewardesses in uniform. I would appreciate any pictures sent me; also letters. Lillian Miller, Station A, Charleston, W.Va.

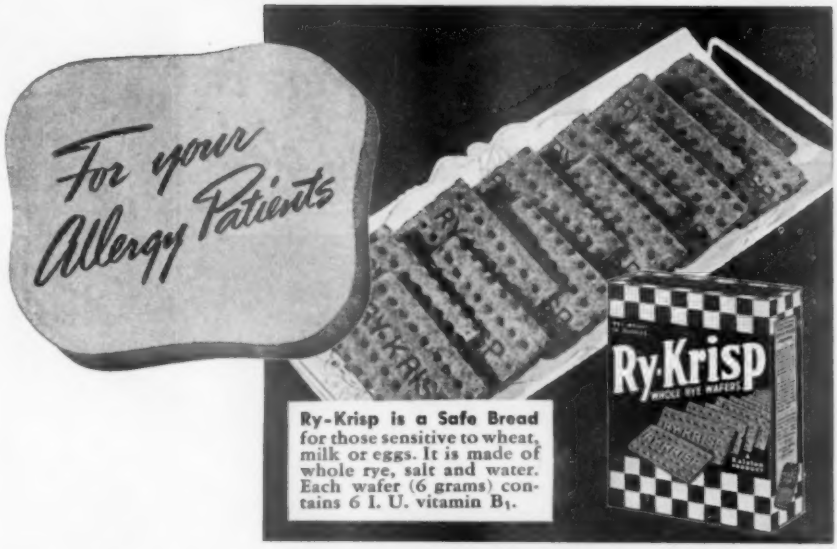
UNIVERSITY OF CALIFORNIA ALUMNAE: Public-health nurses, Class of 1920. We are planning a "twenty-years-after" reunion at the annual dinner in May. We'd like to have 100 per cent attendance. Or, at least, letters from those of you who are too far away to attend. Please write me for further details. Alice Burton, 391 Adams St. Oakland, Calif. [*Turn the page*]

ST. JOSEPH'S ALUMNAE: We should like to hear from all graduates of the training school. Where are you living? What are you doing? Have you married? If you have not received a blank for information, write me. Elizabeth Emore, historian, 514 P.K. St., Reading, Pa.

GRACE AYERS: I'd so like to hear from you. Some of our mutual friends told me you were in Los Angeles. Won't you write? Helen Schrader Edgington, Modesto, Calif.

TOLA McADON: Can anyone help me locate my friend Tola? She graduated from a nursing school in San Antonio, Texas about ten years ago. I'm very anxious to know where and how she is now. "Jinks." Jennie Kaul Oswald, 410 E. Tremont, Hillsboro, Ill.

Where to find our advertisers



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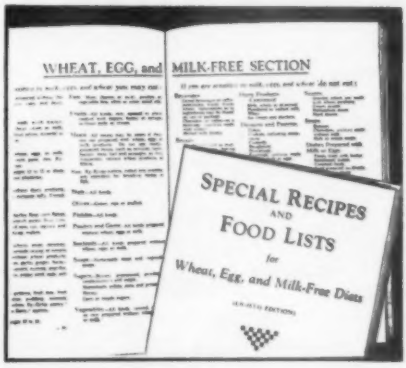

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Interesting products

What is your "I.Q." on new products and services? Here is a ready check-list to keep you up-to-date. You may have samples or literature by writing the manufacturers whose products are described on this page. Be sure to give your registration number, however. The service is available only to registered nurses.

VACATION: It's not too soon to be thinking about it. Nurses proverbially have to plan vacations to fit busy schedules. If your "time off" comes in Spring or early Summer, now is the time to start a little research for travel bargains. Are you headed for Alaska, Mexico, or Lake Louise? Or are you Fair-minded again this year? HAPPINESS TOURS has planned a series of all-expense trips, which they think will suit your pocketbook. Tours range from $35 to $229, can be arranged for parties or individuals. For free folders, write to Happiness Tours, Dept. RN 3-40, 39 South State St., Chicago, Ill.

STOCKING-AID: Do your stockings wear out quickly because you wash them too hard, and use strong soaps? Here's a new angle on the stocking-washing problem. TRISCO Products, Inc. sells a "safety washer" made of smooth glass, which creates a swirling motion, washes your stockings without injury to fibres. With the washer comes a mild, concentrated soap, a rinse solution to take off the shine, and a pair of hosiery driers. Nurses may secure a free booklet by applying to Dept. RN 3-40, Trisco Products, Inc., 3203 Kensington Ave., Philadelphia, Pa.

ELASTIC ADHESIVE: A new bandage combining the advantages of elasticity with adhesive properties has recently been put on the market by Becton, Dickinson & Co. This product of more than two years' research is being widely used by doctors in the treatment of bed-sores, fractures, and skin diseases. The manufacturers particularly recommend it for use with varicose ulcers, where a bandage of this sort can be applied with considerable tension. For free booklet describing the many different uses of ELASTIC ADHESIVE, write Becton, Dickinson & Co., Dept. RN 3-40, Rutherford, N.J.

UNIFORMS: Nobody feels happy in a uniform that comes apart in embarrassing places. You won't be forever sewing on hooks and snaps if you wear EX-CELLE uniforms, with the new "Grippers" fasteners. This company offers a made-to-measure uniform that can be worn with comfort. They will send a swatch of the material, with "Grippers," on request. Address Dept. RN 3-40, Ex-celle Uniform Co., 235 Seventh Ave., New York, N.Y.

MEDICATED TAMPONS: For the prolonged treatment of vaginal and cervical inflammations and infections, MEDIPAX tampon-suppositories have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Your doctor will be interested to know of this product, which includes a medicated suppository and a compressed tampon in an individual applicator. For free literature, write to Allen Laboratories, Inc., Dept. RN 3-40, New Brunswick, N.J.

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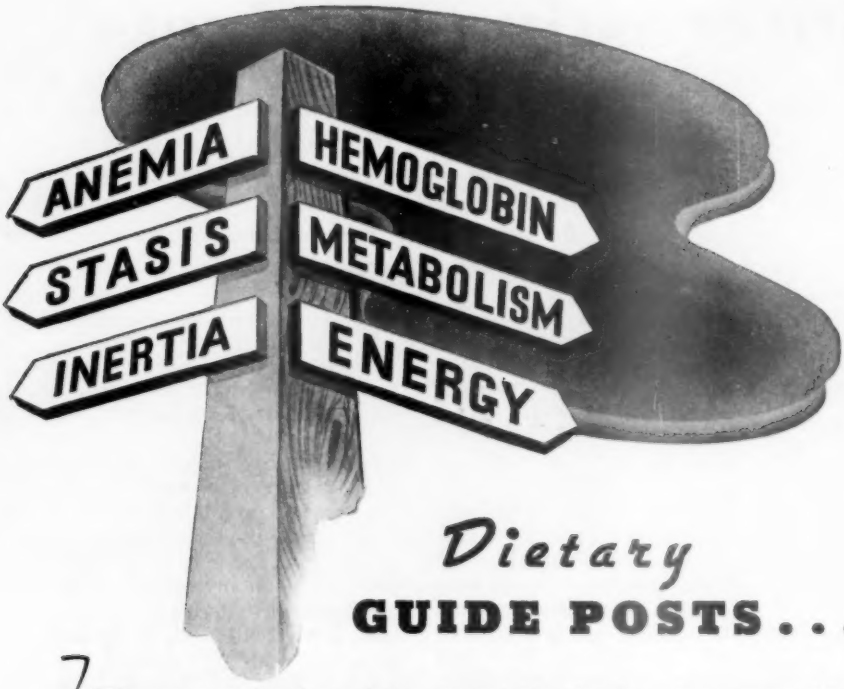

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TWO recent studies have shown the nutritional value of COCOMALT. They are especially interesting because they differ widely in their dietetic fields.

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Therapeutic Diet . . . showed that by giving reinforced feedings of a well-tolerated and nutritious food (COCOMALT) it was possible to materially reduce distressing after effects of tonsillectomies.

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* Medical Record—149:63:1939 ** Archives of Pediatrics—Nov. 1939

R. B. DAVIS COMPANY HOBOKEN, N. J.

Please send me reprints of two COCOMALT studies. RN-3

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There is no charge to registered nurses for the use of this department. To apply for a "position available," simply outline your qualifications in a letter. Address the letter to the correct box number care of R.N.—A JOURNAL FOR NURSES, *Rutherford, N. J. (Send no money with your application. If the bureau requires a registration fee, it will bill you separately.) Submit "positions wanted" early. They will be published in the order received.*

POSITIONS AVAILABLE

***ANESTHETIST:** California. For busy minor surgery located in large medical building. Some combination duties. Salary open. (Placement bureau charges no registration fee.) Box W129.

***ANESTHETIST:** Florida. For beautifully located hospital. Ability, confidence, pleasing personality required. Salary $110 monthly. (Placement bureau charges $2 registration fee.) Box C962.

***ANESTHETIST:** Oregon. Must be experienced, cooperative, able to give all modern anesthetics. Salary $110; meals, laundry. (Placement bureau charges no registration fee.) Box W130.

***ANESTHETIST:** Willing to combine with operating-room nurse, as second anesthetist. Eventual opportunity for full-time anesthesia. Starting salary $85; maintenance. (Placement bureau charges $2 registration fee.) Box C964.

***CENTRAL SUPPLY NURSE:** California. Requires good organizing ability, operating-room background, thorough understanding of central supply system. Private hospital near San Francisco, 125 beds. Salary $115; maintenance. (Placement bureau charges no registration fee.) Box W131.

***DIRECTOR OF NURSES:** Virginia. Over 35; experienced. Teaching not required unless desired. Expenses personal interview paid. (Placement bureau charges $2 registration fee.) Box C967.

***GENERAL DUTY:** California. Several openings: medical, surgical, pediatric, obstetrical services. Large private and county hospitals, San Francisco area. Salaries $75 to $80; maintenance. (Placement bureau charges no registration fee.) Box W132.

***GENERAL DUTY:** New York. For medical-surgical floor of 100-bed hospital. Salary $75, maintenance, first year; $80 second year. (Placement bureau charges $2 registration fee.) Box C970.

***GENERAL DUTY:** Oregon. Private hospital, 30 beds, near Portland. Alternating 8-hour duty. Salary $70; maintenance. (Placement bureau charges no registration fee.) Box W133.

***INSTRUCTOR:** East. Qualified to teach obstetrics, gynecology, principles of teaching, ward management. Large specialized hospital. Salary $135; maintenance. (Placement bureau charges $2 registration fee.) Box C971.

***INSTRUCTOR, NURSING ARTS:** Wisconsin. Preferably Catholic. For opening in 150-bed hospital. B.S. in nursing, teaching experience required. (Placement bureau charges $2 registration fee.) Box C977.

***MALE NURSE:** California. For general duty in large hospital. Salary $90 and maintenance. Increase after three months. (Placement bureau charges $2 registration fee.) Box C973.

***OBSTETRICAL NURSE:** California. General night duty, 50-bed private hospital. Must be able to take responsibility. Salary $90; maintenance. (Placement bureau charges no registration fee.) Box W134.

***OBSTETRICAL NURSE:** Chicago. For prenatal department, large hospital. Post-graduate training required. Salary $90; partial maintenance. (Placement bureau charges $2 registration fee.) Box C979.

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***OFFICE NURSE:** Illinois. Surgeon's office. Knowledge laboratory and X-ray technique. Salary commensurate with ability. (Placement bureau charges $2 registration fee.) Box C981.

***RECORD LIBRARIAN:** California. Registered record librarian. County hospital, 250 beds. Southern part of State. 1½ days off weekly. Salary $85; meals. (Placement bureau charges no registration fee.) Box W136.

***SUPERINTENDENT OF NURSES:** Illinois. Growing hospital in desirable central location. Salary open. (Placement bureau charges $2 registration fee.) Box C985.

***SUPERINTENDENT OF NURSES:** Midwest. Preferably not over 35. To take charge in 90-bed hospital. Starting salary $125; maintenance. (Placement bureau charges $2 registration fee.) Box C984.

***SUPERVISOR:** California. Assistant to director of nursing in 500-bed county hospital. Experience in responsible position required. Salary $125-140; meals. Straight 8-hour duty. Paid vacation. (Placement bureau charges no registration fee.) Box W137.

***SUPERVISORS:** California. One for delivery

**Asterisk indicates position listed by a placement bureau.*

room, one for nursery. Approved 150-bed hospital, central part of State. Salary $100; meals. (Placement bureau charges no registration fee.) Box W138.

*SUPERVISOR, ASSISTANT NIGHT: New England. Pleasant hospital. Starting salary $85. (Placement bureau charges $2 registration fee.) Box C965.

*SUPERVISOR, MEDICAL-SURGICAL: Midwest. For new hospital located small college town. Salary open. (Placement bureau charges $2 registration fee.) Box C974.

*SUPERVISOR, NIGHT: Michigan. Catholic, for pleasant hospital. Salary $110; meals. (Placement bureau charges $2 registration fee.) Box C975.

*SUPERVISOR, OPERATING ROOM: California. Large teaching hospital, coast city. Some university background, teaching ability required. Salary $125; maintenance. (Placement bureau charges no registration fee.) Box W139.

*SUTURE NURSE: California. Midwest graduate with post-graduate course in surgery preferred. Private hospital, 30 beds, small inland town. Salary $100; maintenance. (Placement bureau charges no registration fee.) Box W140.

*SUTURE NURSE: California. For 100-bed private and approved hospital south of San Francisco. Salary $80; maintenance. (Placement bureau charges no registration fee.) Box W141.

*SUTURE NURSE: Ohio: Post-graduate training in surgery required. Salary $85. (Placement bureau charges $2 registration fee.) Box C987.

*TECHNICIAN: California. Thorough training in X-ray technique. Ability to handle large volume of work, busy department, 500-bed county hospital. Salary $115; meals. (Placement bureau charges no registration fee.) Box W139.

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POSITIONS WANTED

ANESTHETIST: Thoroughly experienced. Graduate of Grace Hospital, Detroit. Wants position in 75 to 100-bed hospital. West coast or South preferred. Salary open. Box 340-1.

ANESTHETIST: Eight years' experience. In good standing in National Association of Anesthetists. Widow, 38. Recommendations on request. Salary open. Box 340-2.

COMPANION NURSE: R.N. now employed at Junior college will relieve companion nurse for June, July, and August. Twenty-one years' experience. Episcopalian. Will travel. Salary open. References on request. Box 340-3.

GENERAL DUTY: Experienced in clinic relief work, general and private duty. Alabama registration. Age 22. Colored. Box 340-16.

GENERAL DUTY: Age 39. Private duty and institutional experience for 8 years in large New York hospital. Small private hospital or sanitorium preferred. Registered in New York and New Jersey. Box 340-21.

GENERAL DUTY: Midwestern graduate, some college work. Nine years' private and general duty; also experienced dictaphone and detailed office work. Desires straight 8-hour duty, or medical office work. Box 340-20.

HEAD NURSE: Pennsylvania registration. Experienced general and private duty. Also as charge nurse and relief supervisor. Prefers New Jersey location. Box 340-6.

INDUSTRIAL NURSE: Registered in Indiana; 7 years' experience. Protestant. Single; age 28. Prefers position in Indiana or Illinois. Salary open. References on request. Box 340-17.

OFFICE NURSE: Protestant, 26. Over two years' experience. Typing. Laboratory technique. Salary open. Box 340-7.

OBSTETRICAL SUPERVISOR: Desires post in Alaska. Post-graduate work at New York Hospital; two years' experience. Age 25. Box 340-18.

PUBLIC HEALTH NURSE: New Jersey registration. Age 28. Experience in general duty and private duty, also public health. Salary open. Box 340-9.

SUTURE NURSE: Indiana graduate, age 31. Four years' experience in operating and delivery room. Prefers Midwest or Western location. Salary $80 minimum. Box 340-10.

SUPERINTENDENT: Southern trained; experienced. Age 36. Desires position small city or county institution in Midwest or South. Box 340-19.

SUPERINTENDENT OF NURSES: B.S. in Nursing Education. Extended experience in supervision. Salary open. Box 340-11.

SUPERVISOR, OBSTETRICS: Day or night. Arkansas registration. Ten years' experience. Age 35. Protestant. Salary open. Box 340-12.

SUPERVISOR, PEDIATRICS: Post-graduate training Johns Hopkins Hospital; two years' experience in pediatrics. Desires locate in or near Pasadena, California. Salary open. Box 340-22.

TECHNICIAN: Four years' experience. Age 24. Prefers Washington or Oregon location. Salary open. Box 340-15.

*Position listed by a placement bureau.

Nutrition briefs

[*Continued from page* 21]

vegetables, milk, fruit, and whole grain cereals played a minor rather than a major role in the diets observed.

The conclusions of the study were glaringly evident. Mary and Gracie and Josephine were eating about two-thirds of the foods generally recommended as essentials of any balanced diet.

One young sub-débutante existed chiefly on meat and potatoes. She drank milk occasionally. She thought that food was primarily something tasty and filling.

Did they starve, these uninformed youngsters?

Half their weights were up to normal; the other half were variations over and under the normal. But the subjects did have an average of nine diseased teeth apiece at the average age of seventeen.

The later effects of a consistently bad diet could not be included in this study. But the moral is plain: that nutrition knowledge is not "taking," at least in one age group.—*Bayer, L. M.: Diet of Adolescent Girls. Jour. Pediatrics. Jan. 1940.*

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